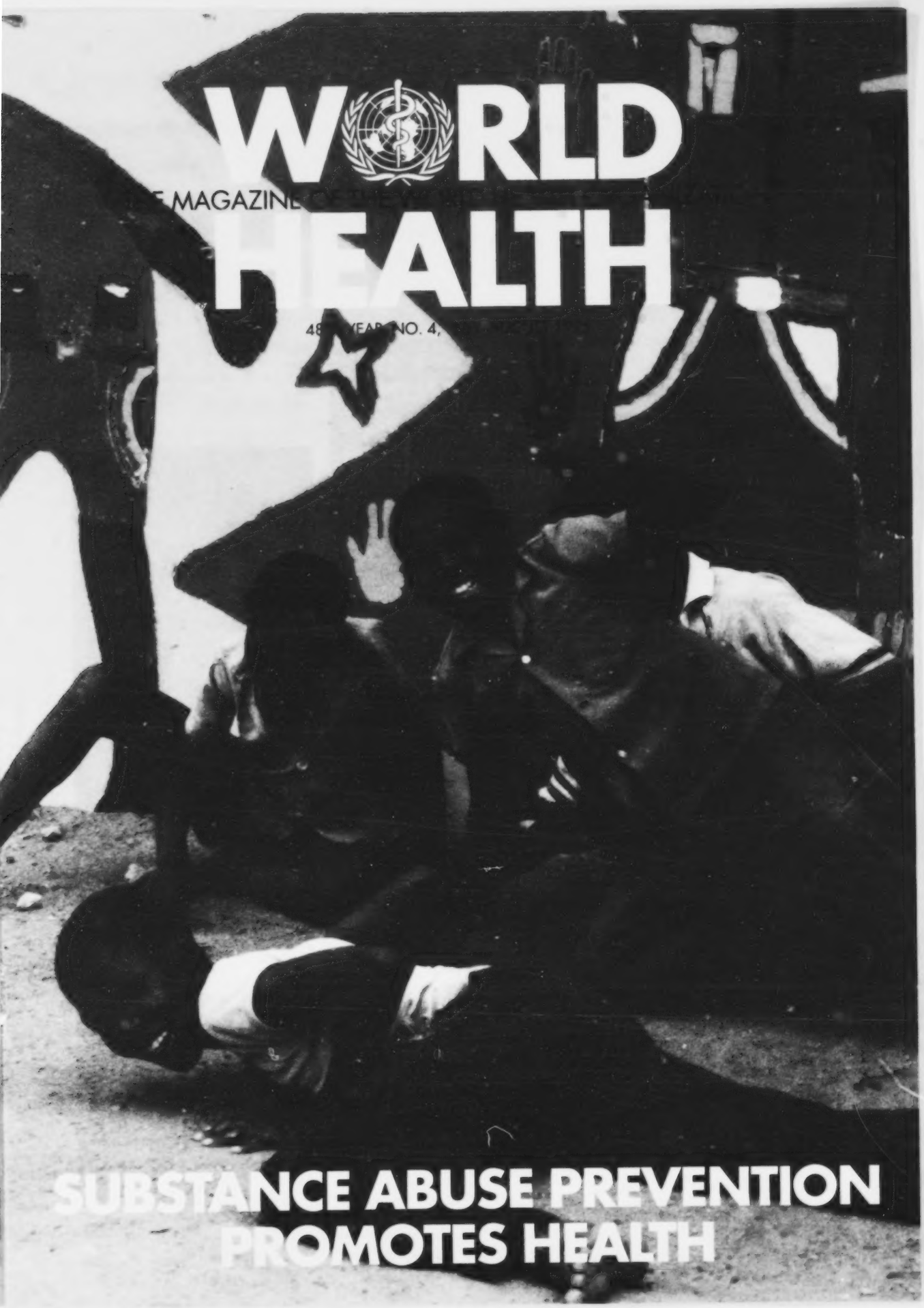
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PROMOTES HEALTH

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Front cover by Andrew Ball for WHO. A joint project carried out with WHO collaboration the Zambia Red Cross and Street Kids International, to prevent substance abuse among street children.

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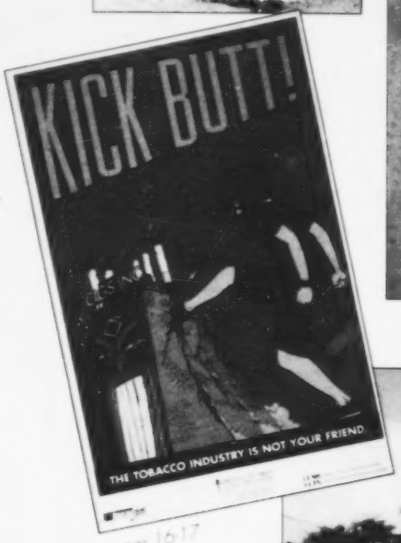

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Editorial

Substance abuse is a health issue

We need to educate communities, particularly the young, on how to cope in a society where drugs proliferate. This is only possible if political leaders, law-makers and society at large recognize the many dimensions of the drug problem and all work together to support the response of health professionals.

Substance abuse has touched every corner of the world. Epidemics shift from one region to another and between different substances. New and often more harmful drugs and patterns of use are replacing traditional practices. Modern drugs of abuse are often injected, bringing the risk of HIV infection on top of drug dependence. The tobacco industry is taking advantage of the huge untapped markets of the developing world. The traditional and controlled use of alcohol in rites and ceremonies is giving way to casual drunkenness.

The problems no longer relate to the use of only one or a few drugs. More often, users move from one drug to another and use combinations of different substances. In many societies, habit-forming exposure to tobacco, alcohol and drugs can start at a very early age, with grave consequences for health in later life. Substance abuse, a major preventable cause of morbidity and mortality in most regions of the world, is thus ultimately a health issue.

WHO, with its unique health expertise and longstanding work in the areas of research, care and treatment, as well as its international network of clinical and research scientists, is ideally placed to confront this issue. In 1990 we established the Programme on Substance Abuse, which addresses health problems and social aspects of the use of various forms of psychoactive substances, including alcohol, tobacco, pharmaceuticals, illicit drugs, indigenous plants and inhalants.

The complexities and scope of drug problems require an equally complex and integrated response. We need to strike a balance in our policies, acknowledging that many psychoactive substances play an important role in our societies and in health care but, at the same time, they may be misused and cause considerable harm. Prevention of abuse can take the form of promoting healthy lifestyles and reducing health risks, while insisting that the rights of each individual should be respected at all times.

Considering the pervasive nature of the problem, which cuts across geographical and sociocultural boundaries, it is essential that we involve communities and primary health care systems in our policies for prevention, care and rehabilitation. Communities must be prepared and equipped to treat and care for those who have already been harmed, and to confront the physical diseases, mental disorders and social disruption which substance abuse entails. We need to educate communities, particularly the young, on how to cope with the risk of substance abuse and especially in a society where drugs proliferate. Such actions are possible only if political leaders, law-makers and society at large recognize the many dimensions of the drug problem and if they all work together to support the response of health ministries and professionals. In addition, of course, health policies must take into account drug issues just as drug policies must take into account and integrate health issues and approaches.

Dr Hiroshi Nakajima, Director-General of the World Health Organization

As we work towards our goal of health for all, the social and health policies we design and implement to address the issue of substance abuse must be based on the concepts of equity and solidarity, emphasizing individual and collective responsibility and placing health within the overall framework of social development and the fulfilment of each individual's potential. ■

A *psychoactive substance*, sometimes referred to simply as a "substance", is any – licit or illicit – product which affects the normal way in which a person's mind or body works, and which may cause intoxication or lead to dependence. Such substances include tobacco, heroin, cocaine, amphetamine, volatile solvents, some prescription medications and alcohol.

Dispelling the myths

Hans Emblad

Healthy alternatives, like sports, help to dispel harmful myths

Since 1990, WHO's Programme on Substance Abuse has gathered information and knowledge through which individual communities can determine how substance use affects them and how they may develop effective local responses.

There are few areas of health which are so steeped in myths as that of substance abuse. For centuries, even millennia, certain psychoactive substances have been credited with magical powers. Powers which may enhance health and performance, powers which may give the user insight and vision, powers which might bring the user closer to his or her creator – and powers which may ravage and destroy. Over many generations, these myths have become entrenched in cultures, religions, and the day-to-day lives of individuals and communities.

Laws, policies and programmes are influenced by community opinions which are sometimes based on myths that prevent rational discussion; any attempt to question age-old beliefs is likely to result in strong community reaction. Drug abuse is often pictured as something to be eradicated through an all-out war. Yet the emphasis is moving away from a war against drugs and towards the promotion of Health for All.

Perhaps it is in dispelling myths and revealing truths that WHO's Programme on Substance Abuse has had its greatest impact. Since its creation in 1990 it has developed and strengthened the knowledge on factors affecting substance use and their health consequences. It has gathered information which illustrates the nature and extent of substance use in all regions of the world, providing a better scientific framework of the global reality. It is through this knowledge that individual communities may discover their own truths, and thus determine how substance use affects them and how they may develop effective local responses for both prevention and treatment.

The information we now have – concerning the spreading epidemic of tobacco use, the health consequences of alcohol use in the developing world, the increasing use of illicit drugs both in developed and developing countries, the risks of HIV infection facilitated by the use of psychoactive drugs, and the impact of substance abuse in workplaces or among indigenous populations – provides a basis upon which international advocacy can operate. These facts have been influential in changing international attitudes and approaches towards the drug issue.

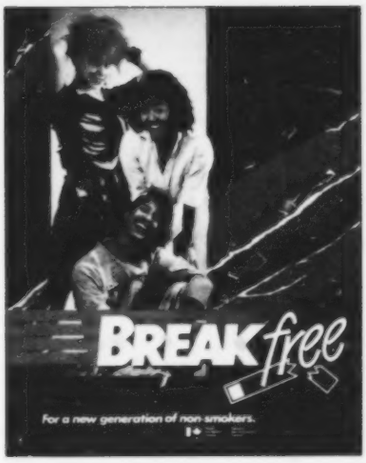
In recent years WHO has intensified its efforts to prevent substance abuse and to reduce its impact on individuals and public health and welfare. Substance abuse has a devastating impact on health and social well-being everywhere in the world. An endless number of stories reflecting this tragedy are reported every day. But there are also numerous examples of constructive prevention initiatives and successful treatment interventions. This issue of ***World Health*** documents some of these problems and also some of the solutions which the WHO Programme on Substance Abuse has encountered and promoted in its work around the world. The conclusion is clear: reducing the magnitude and impact of substance abuse may be a difficult task, but it is not impossible! ■

Mr Hans Emblad is Director of the Programme on Substance Abuse, World Health Organization, 1211 Geneva 27, Switzerland.

Removing the glamour

Diyanath Samarasinghe

We have to try to change the beliefs, rituals and habits that now make drug use appear pleasurable, glamorous or special.



Get a "high" – from being free from drugs.

Activities undertaken in an effort to prevent drug problems are often boring, irrelevant, impractical – and ineffective. Why do they fail? Boring approaches are mostly those which set out to warn young people of the alleged dangers, harm or evil of drugs, coupled with recommendations to be good boys and girls. Young people tend to respond much better to approaches that involve them and allow them an active role.

Following the poor success of lectures and warnings, the emphasis changed to providing "positive alternatives" such as opportunities for leadership, sports and other activities. But giving opportunities for leisure or for improving youngsters' self-image may not reduce the interest in drugs or the willingness to experiment. For instance, we know that many people start drinking alcohol on happy occasions and parties can also introduce young people to drugs. More comprehensive programmes have proved to be effective. But these have been on a small scale and difficult to introduce – especially in poor countries.

Why do people try drugs and why do they keep repeating the experience? The reason most people use a drug a second and third time, after the initial experience, is not that the drug experience was highly enjoyable. Often they did not particularly like it. People who experiment with a drug take it again for a variety of social and personal reasons that have little to do with the drug's effect. These are connected to the symbolic meanings attached to drug use, and social rituals. If those symbolic meanings, beliefs and rituals change, the drug experience itself changes. This knowledge can be used to design preventive activities which are enjoyable as well as relevant and effective.

So we have to try to change the beliefs, rituals and habits that now make drug use appear pleasurable, glamorous or special. Activities based on this idea are producing some very promising results in Sri Lanka. Some communities, and young people themselves, are now working to change or reverse the assumptions and practices that make alcohol, tobacco and other drugs appear great and wonderful.

A community can examine how it refers to drug use and intoxication, and how everybody smiles or laughs when they talk about drug use. Even the stupor caused by alcohol or heroin is referred to as being "high"! The community has to actively contest all those words and expressions that are currently used to make drugs appear special, and replace them by words which more accurately describe the real experience. Reversing the image also involves countering the effect of the special rituals connected with alcohol and drug use. It is often even exciting to make fun of these grand rituals surrounding drug use, and to expose them as rather silly.

There has to be a change in the community's perception of drug use too. If the community begins to see it as rather a flat, boring and silly experience, the efforts can be successful. Eventually the community can hope to reach the stage where even habitual users recognize that they are stuck in a fixed and limited routine, and therefore less able to enjoy *real* life. ■

Professor Diyanath Samarasinghe is Chairman of the National Dangerous Drugs Control Board, Sri Lanka, and Associate Professor in the Department of Psychological Medicine, Faculty of Medicine, Kynsey Road, Colombo 8, Sri Lanka.

Regulatory control and the rational use of drugs

Tokuo Yoshida

New drugs are constantly being developed by the pharmaceutical industry. Reviewing and updating the list of controlled drugs is essential.

It is important to remember that many of the drugs that come under international control regulations are very effective pharmaceutical products of modern medicine.

Since time immemorial, man has been using certain plants to relieve pain and help control disease. The active principles of these medicinal plants are now better understood and some have been chemically synthesized for use in treating illnesses and improving health. Unfortunately some of these drugs became abused, often leading to a state of dependence known as "addiction". This dual nature of certain drugs makes it necessary to limit their use strictly for medical and scientific purposes.

Opium was the first drug whose risk of addiction was recognized internationally following the Opium War in China, around 1840. By 1912, the international community had reached an agreement to control opium. Since then, many other drugs have also been brought under control. Because of the international nature of drug problems, especially the smuggling of illicit drugs across national boundaries, there is need for concerted action at the international level. Today, three major drug control treaties define the various control measures to be applied at the national and international levels. They are:

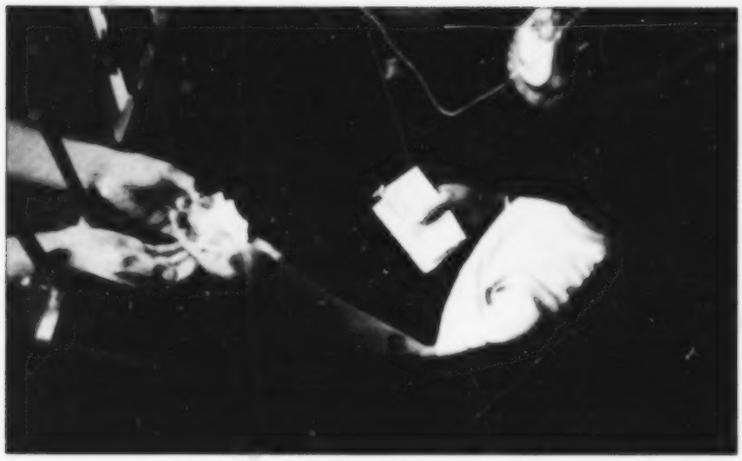
- the Single Convention on Narcotic Drugs, 1961 (for substances derived from opium, coca leaves and cannabis, and synthetic substances similar to these);
- the Convention on Psychotropic Substances, 1971 (for hallucinogens, stimulants and depressants of both synthetic and natural origin);
- the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

Unlike the first two conventions, WHO has a less specific role to play in applying the last convention, which aims at strengthening control measures against the illicit traffic in drugs.

The first two of the above conventions give WHO specific responsibility to review psychoactive substances from a medical and scientific point of view, and to make recommendations to the United Nations concerning their international control. Although the UN takes the final decision on the international control status of psychoactive substances, WHO provides the medical and scientific basis for that decision.

This review by WHO is carried out through the regular collection of information on substances of abuse, and through timely assessment of collected information by the Expert Committee on Drug Dependence. Since 1949, WHO has reviewed more than 400 psychoactive substances. Based on WHO's recommendations and the decisions of the UN, the number of controlled substances has increased by five and a half times (to 116) as regards narcotic drugs and by three times (to 111) as regards psychotropic substances.

The control system has been successful in many countries in limiting the diversion of licit drugs into illicit distribution channels.



Drug trafficking is highly organized – all the more reason for concerted regulatory control at the international level.

However, some developing countries do not have adequate means to implement regulations effectively. In response to requests from such countries, WHO supports national efforts to improve their regulatory systems.

Changing patterns

New drugs are developed by the pharmaceutical industry in pursuit of more effective treatment, but also by chemists in clandestine laboratories in an attempt to avoid existing legal controls. Some of these new drugs have a similar abuse liability to those already under control. In order to cope with the changing patterns of drug abuse, it is vital to constantly review and update the list of controlled drugs.

It is important to remember that many controlled drugs are very effective pharmaceutical products of modern medicine. Morphine, for example, a narcotic drug derived from opium, is an effective analgesic to control severe pain in surgical operations or to mitigate chronic pain experienced by many cancer patients. Codeine is a mild pain killer, also used for the suppression of coughs. Phenobarbital is essential for the control of some symptoms of epilepsy. Several benzodiazepine-type depressant drugs, although abused by some people, are effective medicines for anxiety and insomnia if used properly.

Cumbersome procedures

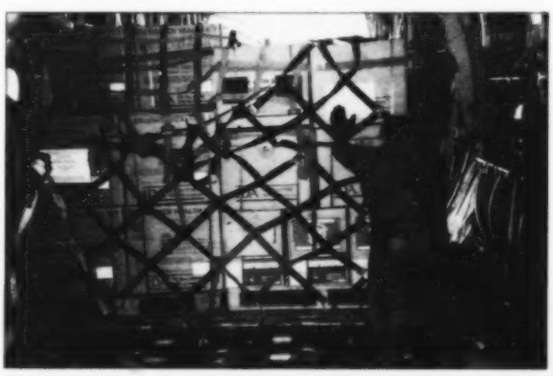
International regulations define the procedures to follow in handling controlled drugs, but they are not designed to restrict the therapeutic use of such drugs. However, when these procedures and reporting systems become too cumbersome, they discourage the use of controlled drugs for medical purposes. This contradicts the aim of the regulations, and it is the patients who suffer.

In order to avoid excessive controls becoming an impediment to the appropriate therapeutic use of controlled drugs, WHO advocates a more balanced regulatory approach. This approach is particularly important during emergency relief operations. More simplified regulatory procedures are needed in order to ensure that humanitarian supplies of controlled drugs reach the sites of emergencies without delay. WHO is collaborating with other UN organizations to explore practical ways of permitting a quicker response to the health needs of disaster-stricken populations.

An excessive fear of addiction can reduce the prescribing of controlled drugs. Freedom from pain is an important element of good care, particularly for patients suffering from incurable diseases, yet in some countries only small quantities of narcotic analgesics, such as morphine, are allotted to control chronic pain in terminal cancer patients. This concern that the medical use of morphine and related drugs might fuel the problem of drug abuse in the community has been identified as one reason for their underuse. In studying this matter, WHO experts became aware of the existing misconception about the definition of "addiction", and made it clear that the manifestation of withdrawal syndromes in cancer patients who are given morphine should not, by itself, be considered as evidence of "addiction".

In the case of hypnotic and anxiolytic drugs, it is known that excessive prescription can lead to long-term habitual use, continuing even after the disappearance of the illnesses for which these drugs were initially prescribed. Through educational activities in collaboration with professional organizations, WHO promotes rational prescribing practices to avoid both underuse and overuse of controlled drugs. ■

Mr Takuo Yoshida is Chief, Regulatory Control Unit, Programme on Substance Abuse, World Health Organization, 1211 Geneva 27, Switzerland.



More simplified regulatory procedures are needed to maintain the flow of humanitarian supplies of controlled drugs.

Indigenous peoples and substance use

Andrew Ball

An Australian poster warns indigenous communities about the risk of alcohol

There are an estimated 300 million indigenous people worldwide, living on their traditional lands in over 70 countries. They are called indigenous or aboriginal peoples because they were living on their lands before settlers came from elsewhere. They have a great cultural, ethnic, linguistic and religious diversity, ranging from hunters and gatherers living in inaccessible rainforests to business leaders in the world's financial centres.

Nevertheless, most indigenous groups share a common heritage in their use of psychoactive substances. Over the centuries, they have come to learn about the mind-altering properties of many of the naturally occurring substances around them. These are often highly valued for their medicinal and nutritional properties and for their use in religious practices. Hallucinogens, including certain types of mushrooms and the cactus peyote, have been widely used among communities in Central and South America to access the spirit world and for initiation ceremonies. In Asia, opium has a long history of use for relaxation and as a medicine to relieve chronic pain and gastrointestinal problems. In Africa, the use of cannabis, fermented beverages and khat forms part of the normal lives of some indigenous peoples. Elsewhere we find the use of coca leaves in the Andes to ward off hunger and to provide energy; the ceremonial use of tobacco among North American Indians; and the social use of the shrub root kava by Pacific island communities.

Within these cultures, strict taboos and restrictions have helped to regulate the use of traditional psychoactive substances. Whereas many communities have maintained their traditional practices because of their isolation from the rest of the world, many more have seen their cultures eroded in the face of assimilation and the integration policies of dominant ethnic groups. As global development occurs, more and more communities are exposed to "outside" attitudes and beliefs – as well as to non-indigenous psychoactive substances and new ways of using traditional ones.

Disastrous impact

Where there is no tradition of use and social control, the introduction of new substances into communities can be devastating. One need only consider the disastrous influence of alcohol on such communities as the Australian Aborigines, New Zealand Maoris, North American Indians and Inuits. A change from opium-smoking to opium- and heroin-injecting among the hill-tribes of South-East and East Asia and certain groups in Central Asia has been the major factor in the spread of HIV and other blood-borne infections within those populations. In addition, inhalant abuse particularly affects young people.

The WHO Programme on Substance Abuse has started a project on Indigenous Peoples and Substance Use involving all regions of the world. Individuals from ten different communities have prepared case-studies on substance use. Besides assisting indigenous peoples themselves to assess the problems and to plan appropriate responses, the project hopes to encourage governments, in association with these communities, to develop policies for addressing such issues at a local level. ■

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Drugs and sports

Jerri Husch

In a growing number of sports and physical activities, from body-building to swimming and from athletics to football, there has been a dramatic rise in the harmful use of substances to improve their performance, not only by elite and professional athletes but by amateurs as well. In response to international concern over the prevalence of health and social problems related to drug use in sport, in 1992 WHO started a global project to help countries to develop and carry out abuse prevention activities. An early product of the project, the 1993 report on *Drugs and sports: current issues and implications for public health* offered an overview of the problems associated with the non-therapeutic and illicit use of drugs in sports. It also summed up current national and international efforts at prevention and education, and stressed the need for more cross-cultural data.

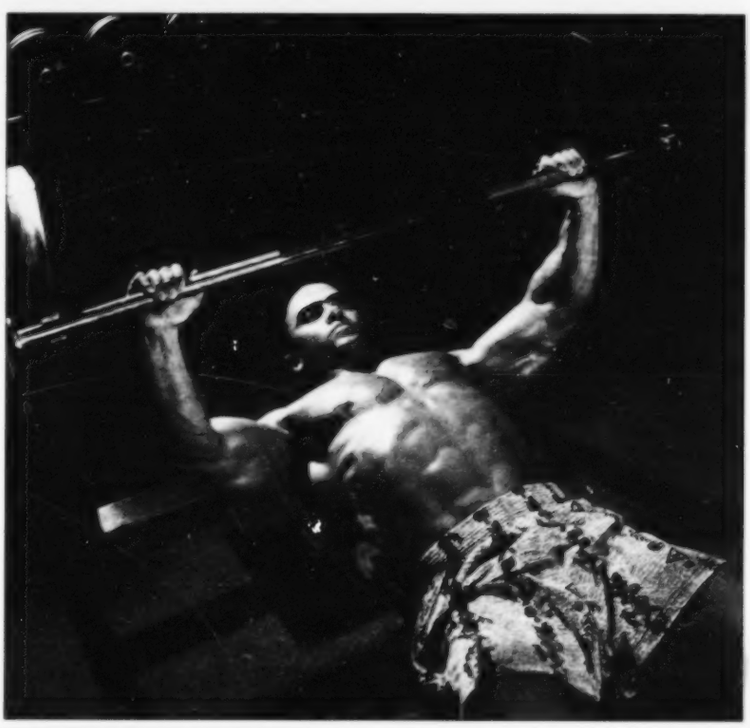
Later research, with data collected from in-depth interviews and focus groups in nine countries, showed that – although patterns of drug use varied – some form of drug use existed in almost all sports and across most age groups. The potentially harmful use of substances took many forms, including overuse of untested food supplements and vitamins, damaging reliance on therapeutic drugs to treat injuries, and the taking of large doses of anabolic steroids. In general, the data suggested that harmful substance use among athletes is part of a dynamic and extremely complex process related to social, physiological, psychological, economic and political variables. No simple pattern of substance use emerged, except that a large number of nations and many different sports were affected.

Efforts to regulate and control the use of drugs in sporting activities have focused on developing new methods of testing and on educational programmes. Testing is usually based on the rationale that the substance gives the user an unfair advantage and may also harm the user. These criteria play an important role in defining the laws and regulations of international sport federations, national governing bodies and international championships with respect to the banning of certain substances. The testing of athletes has been viewed as the primary means of deterring the non-therapeutic use of drugs in sports.

Education and prevention programmes vary according to their emphasis, their organizational structure and their relationship to governmental agencies and other national and international sport bodies. Some programmes place prevention efforts within the domain of sports medicine and the health professions.

Given the diversity of cultural needs and the educational responses, WHO's Programme on Substance Abuse has developed a strategy based on the various stages by which target-specific projects can be developed. For people planning such projects and devising training materials aimed at preventing illicit drug-use in sports, the newly published ***Programme development manual for drugs and sports*** offers step-by-step instructions in programme development. ■

Dr Jerri Husch is a scientist who was formerly with the Programme on Substance Abuse, World Health Organization, 1211 Geneva 27, Switzerland.



New methods of testing alone will not control the use of drugs in sporting activities, they must be backed up by health education.

Street girls and substance use

Kathia M. Butrón

Among slum children, the burden of poverty falls heaviest on girls, who often have to care for their family at an abnormally young age

The street girls in Latin America resort to substance use as a refuge from pain and hunger. Today some are able to improve the quality of their lives – with a little help from the community.

In recent decades many Andean farming and mining families have abandoned the fields and mines and have moved into shanty towns, without water, electricity or basic services. There they remain trapped indefinitely, hoping to improve their income, an almost impossible hope in view of the country's economic situation.

Thousands of women in Latin American cities are born into poverty and discrimination; their life histories are made up of thankless tasks which they must carry out in order to survive in a society which has no room for equity and solidarity. The girls in these slum areas have to assume responsibility for the family from the most tender age: they cook and care for the smaller children while the father, mother and brothers seek work; their only compensation is the affection of their little brothers and sisters, whom they will visit occasionally after leaving the home so as to feel once again that special kind of love that goes with poverty. At night the father returns home drunk and very often the mother is in the same state; violence becomes a routine family drama.

Adolescence complicates the position of these very young housewives. This may mean that they are frequently harassed and raped by neighbours, family members and strangers who take advantage of their helplessness. These new humiliations and abuses often drive them into the streets where the hardships and dangers seem more bearable in a setting of freedom and adventure. Some may move to another town to "begin a new life".

At an average age of 13 these girls take the decision to face life on their own, after having endured difficulties that are much less common in richer populations.

In the streets there are three boys for every two girls; the boys are aged between 11 and 15, the girls between 13 and 18. The difference is accounted for by the fact that the girls are attached to their little brothers and sisters and stay at home longer.

Life on the street

Once in the street, the girl will join up with a boy younger than herself; this union requires absolute fidelity on her part but tolerates infidelity on the boy's part. She washes the clothes and looks after the belongings of both in return for being protected from harassment by policemen, pimps and other street boys. The street girls learn to defend themselves and occasionally take a knife to their attackers. They perceive the police as their main enemy.

Despite their high levels of sexual activity, there are few pregnancies that go to term; the girls

Life is full of uncertainties for many young women in Latin America

At a shelter for street children set up under a WHO project in Cochabamba, Bolivia, girls can learn skills and prepare themselves to have a family of their own

believe that a pregnancy or a child guarantees the stability of the couple, although in reality this is not the case. Consequently, fertility is greatly valued and contraceptives are rejected. Abortions on the other hand are common, but they may often confuse menstruation with abortion. There are also clandestine abortions involving mixtures of coffee and oil, or latex, or getting someone to walk on the girl's back, and so on. They have no one to advise them, but usually they have a girl-friend in whom they can confide.

They survive by a combination of strategies, ranging from begging and selling sweets or fruit to robbery and employment as maids. They resort sporadically to prostitution to get over sentimental frustrations or to meet urgent financial needs.

During leisure hours they meet in mixed groups to have fun, to steal, and to indulge in the only thing that society offers them to alleviate pain and hunger and to afford them a few moments of peace and euphoria: the cheapest possible psychoactive substances – glue, petrol, coca paste and a fermented beverage called chicha. Sometimes the boys get the girls drunk in order to rape them. Some of the girls smoke coca paste with their companion. Certain groups of smokers have initiation rituals for the girls, for example having sex with ten boys in succession.

In order to pass unnoticed, they all cultivate an unfeminine look: they wear trousers and T-shirts, keep their hair short and pay no attention to their appearance or hygiene. They only bother to make themselves clean and tidy when they go to the shops to buy inhalants.

An unknown future

These girls become depressed and constantly reproach themselves for leading a life with few pleasures and from which so much else is missing; self-mutilation and suicide are common. At around 18 years of age they leave the streets to try and settle down to family life. These are women who, after all their misfortunes and diseases, still retain the ability to help and love others, and the decency to attempt a different lifestyle. For the moment there is no knowing what the future has in store for them.

A WHO project for street children in Cochabamba, Bolivia, has given them the opportunity to express themselves and tell their stories. It also links them with the institutions which can respond to their needs. Our most outstanding success is that we can accompany them to the medical clinic and prenatal clinic and thus solve many of their problems. They are also helped to obtain an identity document and to find work or a place at school. They take part in discussions about their sexuality and reproductive health, and have learned new skills which they used to think were beyond their reach. In several cases, they have received support enabling them to lead a stable and independent life as a couple, and have been given guidance in the care and education of their children.

With very few exceptions, it has been found that these young girls' ability to recover is intact and that the "school of the street" has given them experiences that prove very useful for improving the quality of their lives – with a little help from the community. ■

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Women and substance abuse

Pia Bergendahl & Lee-Nah Hsu

Women's tolerance to most drugs is lower than that of men

In most countries, psychoactive substance use has traditionally been a problem affecting males. But with the rapid social and economic changes over the past few decades, there has been a dramatic increase in this problem among women in both developed and developing countries.

Examples of this can be found all over.

- In one European country between 1970 and 1985, deaths related to alcohol dependence increased tenfold for men and 20-fold for women.
- In one African country, tobacco, alcohol, tranquillizers, cannabis and stimulants are now increasingly used by women, and more recently cocaine and heroin are also available.
- In one Asian country, while the use of psychoactive substances is still low among women, their use by men is having a major impact on women and families. Among the poorest, up to a third of total family income may be spent on alcohol and tobacco products.

Women and men respond differently to alcohol and drugs, women having a lower tolerance to most substances. Since many women substance users are of child-bearing age, the effects on the developing fetus are of serious concern. Especially, women and their partners should be made aware of the risks when alcohol, tobacco and other legal substances are used during pregnancy.

The use of psychoactive substances facilitates the spread of HIV infection through sexual contact or needles shared by injecting drug users. In many societies drug use, drug dealing and prostitution are closely connected; consequently the women involved are at high risk of infection with HIV and other sexually transmitted diseases.

Inadequate health care

Services for women substance users are often non-existent or limited, especially in the developing world. Where treatment or rehabilitation programmes do exist, the special needs of women are usually not addressed. For example, women might need help to arrange for the care of their children before entering treatment. During treatment feelings of guilt and shame, as well as difficulties in relationships, should be considered. While men more often use alcohol and illicit drugs, many women turn to prescription drugs, such as tranquillizers. In addition, they often consume alcohol and drugs at home, so that their abuse problem is less publicly visible. Among adolescents alcohol and inhalants are commonly used substances. Although young women are less likely to be users of illicit drugs, their use of cannabis, amphetamines, heroin and other illicit drugs is increasing, and the use of multiple drugs is common.

As for tobacco, the increasing prevalence of tobacco smoking among women is alarming. In many developed countries the number of women smokers is rising to the same level as that of men. In developing countries more and more girls start smoking. In spite of well-known health hazards, tobacco products continue to be aggressively marketed, targeting women with false messages of emancipation, especially in developing countries.

Women as resources

To deal with these problems the focus must be on both men and women, taking into account the effects on the family and children. Women who do not use substances can suffer from their use by a partner or other family members; for instance, a family's income for food, health care and education may be spent on alcohol, tobacco or drugs. Domestic violence is often associated with alcohol or other drug use.

At all levels – international, national and local – the issue of women and substance use is increasingly being recognized, as is the important role of women. Women assume the major responsibility for health care within the family, and are often concerned about the social and health situation in the community. Thus women, especially if training and education can be provided, are instrumental in preventing substance abuse and its potential harmful consequences. ■

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Drugs and the law

W. Lane Porter & William J. Curran

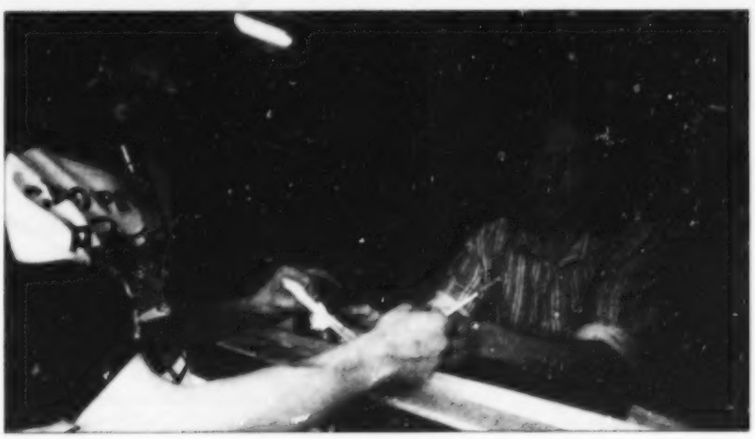
To what degree can the law help to achieve and sustain public health goals in treatment and rehabilitation programmes for drug and alcohol dependence? The objectives of WHO's Programme on Substance Abuse include developing projects to strengthen national health care systems, promoting solutions at the local level, and initiating research to ensure that practitioners maintain their objectivity and adhere to high scientific standards. As part of these activities, the Programme has supported a two-year study of policies and legislation for drug and alcohol treatment and rehabilitation, which involved some 80 countries.

Substance abuse treatment services are most effective when supported by appropriately crafted legislation. The linkage of law, policy and public health programmes is particularly significant for the treatment of substance-dependent persons. Individual liberty is often at stake. While voluntary admission to treatment is preferred, compulsory civil commitment legislation is often available to the courts to order involuntary admission to an inpatient facility for treatment of drug or alcohol dependence, on the grounds stated in the civil law.

International conventions

Under international drug control conventions, countries have adopted policies and laws to control the supply of illicit drugs. Many countries have enacted legislation providing for drug-dependent individuals to be given treatment under the criminal justice system; this too is encouraged in the conventions. The harmful health consequences of substance use have a big impact on other public health areas, including HIV infection and AIDS. Changes in laws have been needed to enable public health measures to discourage drug injecting and oblige people to enter treatment or other health assistance programmes. In some places legislation permits the dispensing of methadone (a heroin substitute) and lawful needle exchange, sometimes coupled with treatment.

Our study reveals that many legislative definitions need revision, to conform to modern international nomenclature standards. Legislation should also protect the human and civil rights of patients and their dignity. And it should consider the confidentiality of all information about those seeking and receiving treatment.



Exchanging a used needle for a clean one. Legislation permits such exchanges in some countries as a preventive measure against HIV infection and AIDS.

Helping rather than hindering

Certainly legislation should be viewed by the public health community and the public as helping rather than hindering the development of programmes for substance abuse treatment. Most of the participants in the study concluded that legislation is helpful. For example, Dr Medina Mora, Head of the Division of Epidemiological and Social Research, Mexican Institute of Psychiatry, reported in 1993 that legislation and regulations in her country are comprehensive and have stimulated the development of such programmes. Treatment and rehabilitation are given particular emphasis, and special programmes to treat drug-dependent persons exist within the major health institutions. She concluded that law is certainly helpful, but it has to be integrated in global programmes so as to make services available and encourage their use by the dependent populations.

The current decade 1991-2000 is the United Nations Decade Against Drug Abuse. Under the Global Programme of Action adopted by the UN General Assembly, national strategies in the health, social, legal and criminal fields should contain programmes for the social reintegration, rehabilitation and treatment of problematic alcohol and drug users and drug-dependent offenders. WHO's Programme on Substance Abuse research will promote these goals, but will also advance the role of law in promoting effective public health programmes at the country level. ■

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Community-based treatment

John Howard

Special camps in India, set up in or close to villages, are an innovative example of the community approach to alcohol or drug use problems. They show that everyone can be given access to all health services.

"Camps" are proving successful in treating and preventing substance abuse in the community

The users of psychoactive substances are disadvantaged by having limited access to health and social services. They may be denied access to those services, or, because they are marginalized and viewed as criminals, they may be considered "less deserving" than non-users. Access can be easier if the substance in question is licit (i.e. alcohol, tobacco or prescription drugs); if the substance is illicit, substantial difficulties emerge.

Viewing substance users as akin to "sinners" and their problems as self-inflicted and worthy of condemnation or punishment may only exacerbate the medical, psychological, social and economic problems of affected individuals, their families and their communities. However, a different approach to substance use and its related consequences could dispel some of the myths and ensure that these persons enjoy the same access to treatment and the same quality of care as non-users. This approach can be brought about through primary health care with strong community involvement in health.

Primary health care and community participation address disease prevention and control based on the principles of political and societal commitment, universal access, partnership, intersectoral cooperation, equity and the use of appropriate technology. Of central importance is that the people themselves participate in taking decisions, and in carrying out and managing development programmes and projects. Participation and involvement are considered to be basic rights of everybody, and are central to the success of development efforts.

The community approach has been tried out in South-East Asia, but in the past has been seen as a worthy but somewhat unprofessional way to treat substance dependence, since many people hold that the necessary expertise for such treatment can only really be found in specialized institutions. Consequently, valuable indigenous responses have been devalued or compared unfavourably with attempts to appear "modern", "developed", "Western" or "scientific".

Treatment camps

In India, a "camp" provides a service which is not normally available to a community. It may take place within the community or village, for example in a school or a religious facility, or even in tents. The treatment occurs as an outreach activity by a multidisciplinary team under the auspices of a hospital (such as the TKK Hospital in Madras) or of a health service (such as the Opium De-Addiction, Treatment, Training and Research Trust, Rajasthan).

The objectives are:

- to provide treatment for alcohol- or other substance-dependent persons living in their own villages;
- to make use of existing community support to help in their recovery;
- to create awareness among the population about problems associated with psychoactive substance dependence.

The goals are abstinence, in accordance with India's Constitution, and a general improvement in life (work, family, interpersonal relationships and so forth).

During visits to different villages the health staff select an enthusiastic and cooperative host organization, a doctor in the local area, and a hospital not too far away from the camp site. The host organization arranges free accommodation for the camp and assists in identifying and motivating those who need treatment. Volunteers are briefed about the camp, substance dependence, the risk of relapse and their own role. After the camp the hosts – often a school, a religious group or other organization – act as support persons, encourage follow-up, monitor progress, and provide other assistance as needed.

The first three days of the 10–15-day camp period involve physical and mental examinations, and the administration of medication (analgesics and anxiolytics) to assist with withdrawal symptoms. The physical examination also identifies any other medical conditions requiring treatment, especially tuberculosis. Social workers, counsellors, family members and volunteers provide encouragement and there is much emphasis on participants helping each other. Interventions include prayer, education sessions on substance dependence and its impact on users and others, meditation, group therapy, individual counselling, and efforts to instil new values. The outpatient family programme provides information about substance dependence, and motivates family members to share the participants' pain and to develop trust and a caring attitude.

The key findings from this approach have been that, with minimal infrastructure, effective treatment and quality care can be provided at low cost (the total cost for a camp is less than US$ 2000). The therapy is appealing, even to illiterate villagers, and the entire community becomes involved in the process. Moreover, it has been reported that up to 70% of treated alcohol-dependent persons have remained abstinent one year later.

The camp approach is consistent with many other health interventions which aim to educate and assist communities to identify their own health needs. It also encourages health promotion partnerships to be formed between government bodies, nongovernmental organizations and the community. Instead of subjecting substance users to punitive, legally sanctioned responses which entirely ignore any health implications, the local police can align themselves with such projects.

Religious festivals, rituals or ceremonies serve to mobilize the community to action, and affirm the relevance and centrality of the spiritual dimension in the lives of all. This approach has played a significant role in demystifying substance use and dependence, and encourages the notion that rehabilitation should, and does, begin prior to detoxification. Medicine necessarily plays a central role in assessing health needs and providing pharmaceuticals to alleviate withdrawal symptoms. The camps show that people can be given access to all health services. ■

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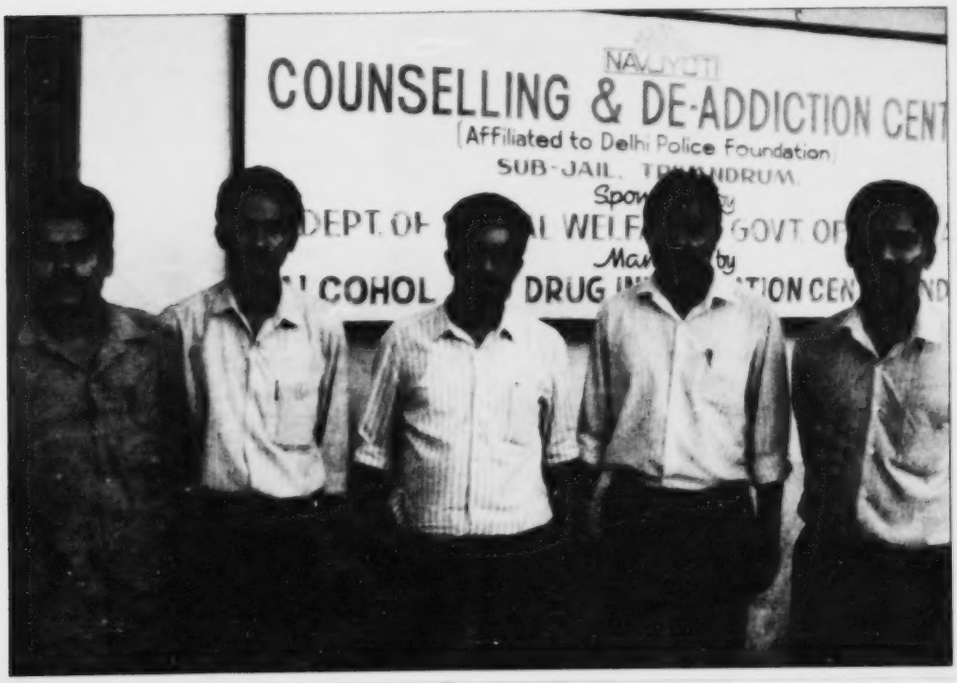


An expert team provides counselling and de-addiction treatment in a prison setting

Facts, figures and estim

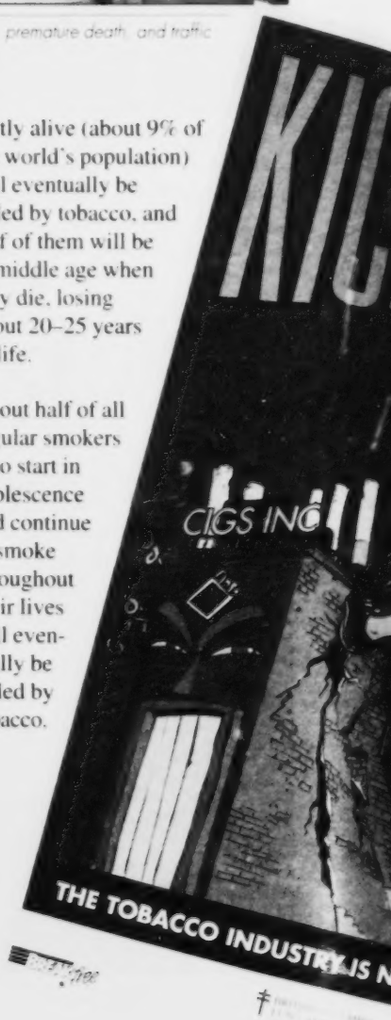
ALCOHOL

- In developed countries, typically 70–90% of adults consume alcohol. Studies in a number of industrialized countries suggest that 5–10% of drinkers are dependent on alcohol.
- Following a period of increase, alcohol consumption has stabilized or decreased over the last decade in many but not all industrialized countries, except in Eastern Europe, where there is evidence of a rapid and recent increase in consumption. In many developing countries, alcohol consumption has been increasing dramatically over the last 10–20 years.
- For several diseases, including cancers of the mouth, oesophagus and pharynx, as well as for many forms of injury including motor vehicle accidents, industrial accidents, drowning, falls, suicide and homicide, the contribution of alcohol is well known, the risk increasing steadily with the amount consumed. Epidemiological studies have found that small amounts of alcohol lower the risk of death in men older than 35 years and postmenopausal women, primarily because of a protective effect of alcohol against ischaemic heart disease.
- In age groups where vascular disease is uncommon (e.g., young adults), alcohol-induced illness and death are likely to increase directly with the amount consumed. At these ages, alcohol has been found to be associated with 40–50% of traffic fatalities and other common injuries among males in some countries.
- Alcohol consumption during pregnancy is associated with brain and physical malformations in the fetus.

Alcohol can be a false friend. It plays a major part in illness, premature death, and traffic accidents.

TOBACCO

- Worldwide, there are about 1100 million smokers with 800 million in developing countries and 300 million in developed countries. About 6000 million million cigarettes are smoked every year. In developed countries, about 41% of men and 21% of women regularly smoke cigarettes. In developing countries, about 50% of men but only about 8% of women smoke.
- Tobacco causes about 3 million deaths a year now, with about one-third of them in developing countries. If current smoking trends persist, tobacco is likely to kill approximately 10 million people a year in 30–40 years time, with about 70% of them in developing countries.
- If current smoking trends persist, about 500 million people currently alive (about 9% of the world's population) will eventually be killed by tobacco, and half of them will be in middle age when they die, losing about 20–25 years of life.
- About half of all regular smokers who start in adolescence and continue to smoke throughout their lives will eventually be killed by tobacco.



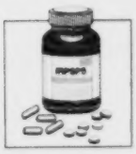
ıtes about substance use

Most of those killed by tobacco were not particularly "heavy" smokers (but most did start in their teenage years).

- Stopping smoking works: even in middle age, stopping ***before*** having cancer or some other serious disease avoids ***most*** of the later excess risk of death from tobacco – and the benefits of stopping at earlier ages are even greater.

ILLICIT DRUGS

- In some developed countries, surveys of adolescents conducted since 1975 show that levels of illicit drug use peaked in the late 1970s and generally declined during the 1980s and early 1990s. In the USA since 1992, levels of use of marijuana and other illicit drugs among young people have increased for the first time in over ten years. Lifetime use of any illicit drug among 18-year-olds in school peaked at 66% in 1981, declined to 41% in 1992 and increased to 46% in 1994.
- In many developing countries heroin and cocaine use is becoming more common and increasingly problematic. In several countries heroin use is increasingly replacing traditional patterns of substance use including opium smoking.
- In many developing countries drug injecting is becoming increasingly common, and in these countries injecting often means the sharing of injecting equipment, with the risk of HIV, hepatitis and other infections.
- One crude estimate suggests that, worldwide, between 160 000 and 210 000 deaths every year are associated with drug injecting.



OTHER DRUGS

- In many developed and developing countries the use of volatile solvents and inhalants is particularly common among younger and marginalized people.
- Physiological and neurological damage caused by volatile solvents and inhalants is often irreparable.
- Licit pharmaceutical products including benzodiazepines are commonly abused in both developed and developing counties. In some African countries for example, over 40% of illicit drug users report using benzodiazepines. ■

Destroying the myth created by vested tobacco interests calls for talent and determination

The overuse or misuse of pills are part and parcel of substance abuse problems.

Drug injection

Gerry Stimson

Ways must be found to reduce the health risks and discourage the spread of drug injecting

In a world of major political and economic change, it is likely that drug injecting will become more common. Ways must be found to reduce health risks and discourage the spread of injecting.

The self-injection of drugs for non-medical purposes is now practised in all parts of the world and raises critical issues for individual and public health. Drug injecting has been observed for many years in developed countries, but in the last two decades these have been joined by many developing countries; the total stands at over 110 countries worldwide.

People inject drugs for pleasure, or because they are dependent on them. Many different substances are injected. Most commonly these are illicitly produced, such as heroin, cocaine and amphetamine, but also a pharmaceutically produced analgesic (buprenorphine) has been used in Glasgow, Scotland, and in Madras, India. In Vietnam, a solution of opium is favoured. Weightlifters wanting to improve their strength and physique inject anabolic steroids or other performance and growth-enhancing drugs.

Injecting is particularly widespread in developing countries that have areas devoted to illicit drug cultivation or production, or through which illicit drugs pass. The area known as the Golden Triangle, encompassing parts of Laos, Myanmar and Thailand, is the major opium-growing area of the world. Opium is converted into heroin in illicit refineries located in isolated areas, and the heroin is destined for the world drug market. As a consequence of this local production, opium smoking was gradually replaced by heroin smoking and later by heroin injection, which then spread to China and India.

Shipments of cocaine from South America and heroin from Asia pass through West Africa en route for illegal markets in Europe and North America. Consequently, Nigeria and other West African countries now have their own local problems with those drugs. In South America, cocaine injecting mainly occurs in Brazil, but not in the coca-growing and cocaine-producing countries of Bolivia, Colombia and Peru, which until now seem to be culturally resistant to the practice of injecting.

Health hazards

The health risks from injecting include damage from the toxic effects of drugs and overdosage due to high doses entering the blood stream. Damage to veins may occur at needle puncture sites. Damage to the heart and circulatory system may result from the injection of contaminants and bacteria mixed with the drugs. Other hazards include abscesses and septicaemia. Blood-borne diseases such as HIV infection and hepatitis can be spread from one person to another through shared syringes.

After the HIV antibody test was introduced in the 1980s, many injectors proved to be HIV-positive. In a number of European countries, drug injectors are the largest group of people with AIDS. In Bangkok, there was hardly any HIV infection

among injectors until 1987: within a few months 40% of injectors were HIV-positive. During the next three years, HIV spread to injectors in southern China, north-east India, Malaysia and Myanmar. A few cities there have world record levels of infection, with over 60% of injectors found to be HIV-positive.

There is now strong evidence that HIV epidemics can be contained. Treatment leading to abstinence from drugs is important. The opiate-substitute drug methadone can be used to detoxify dependent persons, and to stabilize them so that they stop injecting illicit drugs and make other improvements in their lives. This treatment is expensive for poor countries, but community treatment camps where groups of patients from the same village are treated together are proving successful in India and Myanmar.

However, treatment for drug dependence has a low short-term success rate and there are frequent relapses. In the last ten years, many countries have developed public health programmes which aim at risk reduction, helping injectors to change their drug-using and sexual behaviour which could transmit HIV infection. Distributing syringes along with health education has led to reduced levels of risk behaviour in a number of countries. In the United Kingdom, drug injectors now share syringes only occasionally; only 8% of injectors in London are HIV-positive, and 1% elsewhere in the country. Similar low rates are found in Australia.

Some projects train current injectors and other key local people as "indigenous" AIDS-prevention workers. They hand out needles and syringes, teach injectors how to clean a syringe using bleach or some other disinfectant, and give out condoms, at the same time explaining all the health risks. These public health programmes have succeeded in reducing the negative health effects of drug injecting, and there is substantial evidence that injectors can be encouraged to change their behaviour.

In a world of major political and economic change, it is likely that drug injecting will become more common. The challenge for governments and nongovernmental organizations is twofold. The first is to work with current injectors through risk-reduction projects and to improve the accessibility and effectiveness of drug treatment. The second is to find ways to discourage the spread of injecting to new areas and to new groups, but without marginalizing drug users. ■

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A drug user preparing a mixture for self-injection.

MENTOR: an innovative approach to youth drug prevention

With an annual turnover exceeding US$ 400 000 million, the illicit drugs trade is the fastest growing and second largest industry in the world, following the arms trade, but ahead of oil. Availability of these drugs has grown sixfold in 30 years. Abuse and consumption of licit substances – solvents, prescription medications and alcohol – is increasing at a similar pace. Substance use and its associated problems represent a pressing health and social issue that cries out for global response.

To confront the problems associated with drug use among young persons through prevention, a group of international personalities launched an initiative in collaboration with WHO. As a vehicle for this collaboration they have established an independent, apolitical and privately financed foundation named after the mythical tutor entrusted with the upbringing of the son of Ulysses: the MENTOR Foundation.

Working exclusively with and through existing organizations, which will be interlinked through a data network called MentorNet, MENTOR fills an existing void by helping to identify and interconnect successful local drug prevention programmes worldwide. It creates a mechanism for exchanging experiences and for studying, improving and replicating successful methodology; it provides programmes with the latest technical findings and fosters interchanges between programmes and technical centres of excellence; it establishes new programmes, based on proven or promising methodologies; and it helps to finance programmes and related research activities.

The Foundation came into being on 10 May 1994, during a ceremony at the United Nations in Geneva. Her Majesty the Queen of Sweden, an Honorary Member of the MENTOR Board of Trustees, announced the launching of the global initiative to the delegates from 189 countries who were at that time attending the Forty-seventh World Health Assembly.

For further information, please contact the Mentor Foundation, c/o Programme on Substance Abuse, World Health Organization, 1211 Geneva 27, Switzerland. Fax: 41 22 791-4872.

Alcohol problems in Russia

Alexander V. Nemtsov & Vladimir M. Shkolnikov

The Soviet system launched a grandiose anti-alcohol campaign in 1985, but succeeded only in driving illicit trade in spirits into the arms of criminal organizations. By 1993, alcohol consumption was higher than it had been before the campaign.

A large proportion of alcohol-related problems never figure in the national statistics.

Alcohol consumption was traditionally high during the Russian Empire, and in the Soviet Union it reached a peak in 1927 of 3.7 litres of pure alcohol per person per year. This forced the Soviet leadership to introduce a series of restrictive measures that led to some fall in consumption. But a new rise began in the mid-1950s and by 1980 the level stood at 8.7 litres per person per annum. After that, consumption stabilized at a level not too far from the European average of 8.4 litres in 1984.

Actual alcohol consumption in the Soviet population was in fact considerably higher than official sales figures indicated – a result of the brewing of *samogon*, illicit home-made spirits. In the early 1980s, various estimates of actual alcohol consumption averaged around 12.1 litres.

In the Slav and Baltic Republics of the USSR, the harmful effects were considerably aggravated by, typically, the massive consumption of spirits (mainly vodka) at short intervals, taken with insufficient food and often on the street, at the workplace or in shops.

The danger of this type of drinking is the sudden loss of self-control. This is why, in the European regions of the USSR, alcohol abuse is most closely correlated with mortality attributable to accidents, poisoning and injuries.

Grandiose experiment

The alcohol control campaign launched on 1 June 1985 was the last grandiose experiment carried out by the Soviet system on its own people. It sought to reduce alcohol consumption by reducing State production and sale of spirits, and by destroying the production of *samogon*. The price of spirits was increased and the number of sales outlets was cut by 80%.

The sale of spirits fell by 63% between 1984 and 1987 to 3.9 litres per person but the people responded to this draconian campaign with an unprecedented level of protest – the main result being a sharp increase in the production of *samogon*. The illicit trade in spirits gave rise to powerful criminal organizations and "vodka czars", laying the basis for the spread of the underground alcohol market in Russia.

Thanks to underpayment of taxes on spirits and the uncontrolled manufacture or import of large quantities of fake spirits, often prepared from industrial alcohol, the real cost of wine and spirits fell steeply and this accounts for the Russian paradox of increased alcohol consumption against a background of drop in real income. In 1993, actual alcohol consumption had reached 14.5 litres per person, higher than it had been before the anti-alcohol drive. Russia was now one of the foremost consumers of alcohol in the world.

In Russia – as in other countries – it is difficult to ascertain the real number of people with an alcohol dependence, of whom only 2 452 000, or 1% of the population (1993) are accounted for in medical institutions. The number of registered "alcoholics" in Russia has fallen steadily since 1987, obviously because registration procedures have been deteriorating. The real total may be as high as 7–8 million and it is continuing to rise, if the increase in alcoholic psychosis is anything to go by.

Whereas illicit drugs pose a much smaller problem than alcohol, with a total number of drug-dependent persons estimated at between 150 000 and 300 000, the increasing interest being shown in illicit drugs by adolescents and young people is causing concern among health professionals. ■

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Alcohol and economic change

Peter Anderson

A picture of despair. Many people turn to drink as a result of financial and employment problems.

A crisis of alcohol policy still affects the countries of Central and Eastern Europe, where alcohol control measures are associated with previous, repressive regimes.

"Excess mortality" in Russia and Ukraine for the four years 1990–93 has been estimated at 800 000 deaths. These avoidable deaths have largely affected young adult men and have resulted from widespread impoverishment, erosion of preventive health services and social stress. But up to two-thirds of the excess mortality has been due to alcohol-related conditions, including alcohol poisoning and psychosis, murder, suicide and accidents, including drowning, falls, suffocation, fire, and work-related and car accidents.

In the former Soviet Union, an alcohol campaign launched in 1985 was symbolically bound up with the policy of perestroika, and thus with the beginning of political and economic changes. Despite the undeniable success in diminishing alcohol-related harm, the reform provoked deep dissatisfaction and undermined support for the Gorbachev regime. In the three Baltic States, Estonia, Latvia and Lithuania, alcohol issues and the Soviet reform were intertwined with the struggle for national liberation. In other countries of Central and Eastern Europe, Gorbachev's anti-alcohol campaign was followed with less determination, but alcohol policy tended to become more restrictive.

The experiences of the 1980s have contributed to negative attitudes in many countries towards any state regulation of alcohol. Alcohol control is associated with previous regimes, whereas unrestricted marketing of alcohol is perceived as a symbol of positive economic development. Private entrepreneurs are eager to rake in profits from alcohol production and trade, while the Western alcohol industry is searching for new markets, especially in the face of declining demand in their own countries.

Meanwhile, in the absence of effective regulation there is large-scale smuggling of alcoholic beverages, importation without paying duty, trade in low quality alcohol, trade in falsified Western brands, and trade in beverages with extremely high alcohol content. The Polish state lost more than US$ 200 million in duties and taxes during a six-month period in 1989, due to a loophole in the legislation regulating the import of alcohol. In Russia, the state treasury losses are estimated at US$ one million every day, while illegal alcohol traders have profited by about the same sum.

For the countries of Central and Eastern Europe, commodities such as alcohol, and especially Western brands, have become symbols of Western lifestyles, and this is reinforced by television programmes and advertisements that link drinking alcohol with images of freedom and social success. All this makes it more difficult for policy-makers to legitimize any alcohol control measures.

So for the present there remains a crisis of alcohol policy, particularly in Eastern European countries. The public health, public order and public finance arguments for alcohol policy that are used in the established market economies do not yet find their place in many of those countries. Yet, there are signs of positive change. Among certain youth groups, Western values are just beginning to be perceived as incorporating healthy lifestyles, with restrictions and public education about smoking, drinking and an unhealthy diet being seen and accepted as part of the norm. ■

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Alcohol and social change

Vanna Beckman

Examples from southern Africa show how easy access to alcoholic drinks can lead to dependence – an all-too-frequent result of the tremendous social changes in Africa.

Alcohol is too often wrongly viewed as a token of freedom.

While we talk to David in his courtyard on the slope of Mount Kilimanjaro, in Tanzania, his wife comes home carrying a heavy gunny sack of grain on her head. She puts it down with relief. The millet will make a nourishing porridge for the small children who swarm around our knees, visibly malnourished. That is what I think. But Sister Marenga – who is home-visiting to see if the children have put on weight properly after treatment at the Nourishing Centre in Moshi – tells me: "No. All the millet is for brewing. David is a heavy drinker, his wife earns some money through brewing, and the kids still weigh much too little."

This brutal scene flashes through my mind when I think of my studies on alcohol-related questions in Africa. It contains the crucial factors: the drinker; his subservient wife who reluctantly does the brewing because it is her only way to make ends meet; the grain that could be used either to improve the family or to harm it; finally, the suffering children. There are other examples.

- The young girl at the University of Dar-es-Salaam, Tanzania, who declares: "Yes I know all this brewing leads to increased alcohol consumption. But had it not been for the brewing my mother did, I would never have been where I am now."
- The drinking den in Eldorado Park in Johannesburg, South Africa, where some 20 people move round in a strange dance amid sour odours from "skokian", a homebrew mixed with methanol or battery-acid to make it more intoxicating. The people shout, argue, sing and behave in ways that I have only seen in people intoxicated by narcotics.
- Jabu in Soweto Township, South Africa, is an example of "a sober alcoholic", one who will never drink again. He grew up in a bar that his father owned, started drinking in his teens, and by twenty he couldn't keep a job. But by 25 he was finally "saved" by a devoted expert in an alcohol clinic. He shows me his nice little house, his happy-looking wife and his car in which the tape-recorder plays a speech by a member of Alcoholics Anonymous.
- The pleasant, relaxed, friendly and jolly atmosphere of a middle-class suburb of Lusaka, Zambia, early on any Saturday night. Men of all ages assemble in and around pubs and bars, carrying their beers out of doors, chatting, joking and debating. Nobody is drunk yet. This is one of the moments when drinking appears to bring joy and happiness. It is these moments that a drinker remembers, the memories he prefers, rather than calamities that occur later at night, quarrels at home or daily hangovers. He is not inclined to relate these things to his drinking.
- The life of the street children of Lanasia, Johannesburg, seems little different from that in Lusaka. Maybe more of them are begging than doing occasional jobs. But their little plastic bottles with the yellow-coloured glue are the same. Their ways of tucking them away under their arm inside sweaters or shirts are identical. And so are their wild and ruined looks. They are often the children of drug users, or of HIV-infected or otherwise disempowered parents.

There are many reasons for the growing number of social catastrophes caused or aggravated by alcohol. One is the prestige of "Western-style" drinking left over from the colonial era, when beer and spirits were usually not permitted for

Africans. Subsequently, Western alcohol producers made up for the long lack by establishing a brewing industry and helping Africans to import liquors and wine. Moreover, there was the need for cash. How could a poor family living in the countryside earn some cash to pay for a school uniform or a bus ticket? If the wife took some of the available grain and turned it into beer, a neighbour who had earned some money would buy it.

Everyday drinking very easily became a habit when alcoholic beverages abounded everywhere, at quite a tolerable price. How different from the old days when brewing in a community was a big event, and drinking the brew together was an important ritual of cohesion and friendship. Much of today's drinking has certainly kept something of that flavour, with the dangerous difference that it can take place every day and therefore create alcohol dependence. This is an all-too-frequent result of the tremendous social changes in Africa, where old relationships and old norms of conduct are turbulently overturned, and people living on the margin of society are further brutalized by heavy drinking habits.

Whole families engage in distilling kachasu for an income. Such homebrews often contain toxic substances that can cause serious health problems.

To tackle this problem, African peoples themselves will have to mobilize the kind of strength they showed when they liberated their countries from colonialism. In Soweto Township, Jabu told me that he thought alcohol-related problems were as heavy a burden for the Africans as apartheid. Apartheid was fought successfully, and alcohol problems can be as well. On this issue Muslims and Christians can unite, while the temperance movements in several African countries need support to develop the crucial role they once played in the Nordic countries, advocating sobriety, education and cultural values. The very first step, however, is to recognize the problem. ■

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Alcohol and your heart

Alcohol is responsible for much death and sickness, quite apart from the social problems it causes. From a public health viewpoint, therefore, the importance of limiting alcohol consumption is not questioned. Recently a large number of case-control and prospective observational studies from around the world have supported the hypothesis that light-to-moderate levels of alcohol consumption result in a modest but consistent reduction in coronary heart disease. However, many of those same studies show that, with alcohol consumption levels above two drinks per day – or roughly 24 g of ethanol – there is a consistent trend for increased rates of morbidity and mortality from all cardiovascular diseases combined, including stroke, arrhythmia and hypertensive heart disease.

The protective effect of moderate alcohol consumption, as compared to abstaining altogether, is related to the modulation of several well-recognized pathogenic mechanisms that can lead to atheroma and/or thrombosis. In medical terms, these are an increase in HDL cholesterol, a reduction in plasma fibrinogen concentration and decreased platelet aggregation.

Any public health recommendation that simply emphasized the positive effects of alcohol would do more harm than good. A study called INTERSALT has suggested that an increase in mean consumption of only 15 g of alcohol (about one drink) a week would be associated with a 10% increase in the prevalence of heavy drinkers. So it would be irresponsible to advocate moderate alcohol consumption as a means of preventing coronary heart disease. As a strategy for reducing heart disease it would be much better to address the most important risk factors by promoting:

- **smoking prevention**
- **healthy nutrition**
- **regular exercise**
- **hypertension control.**

Contributed by Dr Ivan Gyarfas, Chief, Cardiovascular Diseases, World Health Organization, 1211 Geneva 27, Switzerland.

An African example

S.W. Acuda

A woman boils a mixture of dried corn and water ready for fermenting

Up to the Second World War, publications on major health and social issues in Zimbabwe made no mention of alcohol, implying that this was not a serious problem. Certainly, alcohol had important social and cultural functions, for instance during ritual ceremonies, communal planting and harvesting, and spirit media celebrations. Traditional structures and cultural taboos strictly controlled the production of alcohol, and its use was permitted only to certain people deemed to have attained appropriate levels of maturity.

As more and more Zimbabweans left their villages for the cities, those controls gradually loosened. At the same time there was a tremendous increase in the availability of alcohol, supported by aggressive marketing and advertising. Domestic production of alcohol remains an important source of income for many women. Beer halls and bottle stores ensure the wide availability of all types of alcoholic drinks, and alcohol consumption by both men and women has steadily increased.

Two studies among secondary school students in 1990 and 1994 confirmed that alcohol use and abuse do exist among young people in Zimbabwe. They showed that nearly as many female students drank regularly as males; indeed in a few secondary schools more girls than boys were using alcohol. At a busy primary health care clinic in Harare, 66% of the men and 48% of the women who drank were getting drunk on each occasion, and most of them showed signs of alcohol dependence as well as health and social problems.

In Zimbabwe, messages such as "don't drink and drive" are overshadowed by the much more beguiling advertisements for alcohol. Few attempts have been made to curb them.

Currently about 10% of admissions to the psychiatric unit of a large Harare hospital are due to mental complications of alcohol use. In 1991, it was estimated that 65% of all road traffic accidents in Zimbabwe were due to alcohol use.

Besides easy availability, other factors blamed for the escalation of alcohol problems include rapid urbanization, rapid sociocultural changes, unemployment and economic hardship. In 1987, the government designated the Department of Social Welfare to coordinate all activities for combating drug problems in the country. A resource centre was set up and a National Policy on Alcohol and Drug Abuse was drafted, while pilot projects for community alcohol and drug abuse prevention have started. Treatment and rehabilitation services are provided in government and private general hospitals and at primary health care clinics. But only a tiny fraction of alcohol-dependent persons at present receive assistance.

The mass media's occasional public education messages such as "don't drink and drive" are overshadowed by the much more beguiling advertisements of alcoholic drinks. So far, few attempts have been made to curb them. ■

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Cocaine use: the largest global study ever undertaken

Between 1992 and 1994 the World Health Organization (WHO), in association with the United Nations Interregional Crime and Justice Research Institute (UNICRI) undertook the largest global study on cocaine use ever. Information was collected from 22 cities in 19 countries about how cocaine and other coca leaf derivatives are used, who uses them, what effects they have on the users and the community, and how governments have responded to the cocaine problem.

From the coca leaf chewers of the Andes to the crack smokers in New York and Lagos, from cocaine injectors in São Paulo and San Francisco to cocaine sniffers in Sydney and Cairo, all aspects of the problem have been tackled by the many research workers from various countries who took part in the study.

This project, launched in 1991 by the WHO Programme on Substance Abuse in collaboration with UNICRI, was designed to collect as much information as possible on cocaine use from a selection of countries around the world and to investigate the effectiveness of policies and strategies which address cocaine-related problems.

Four categories of countries were selected for the study: those which grow coca and now have cocaine-related problems, those which do not grow it but have substantial numbers of users and cocaine-related problems, those where cocaine use is not so widespread but is already on the increase, and those where cocaine use as yet presents no problem.

One of the main conclusions of the study is that there is no "average cocaine user": there is an enormous variety in the types of people who use cocaine, the amount of drug used, the frequency of use, the duration and intensity of use, the reasons for using cocaine and any associated problems that users experience. Generally, cocaine users consume a range of other drugs as well.

Cocaine users were found in all regions of the world, both in urban and rural settings. Whereas global use was far more extensive than expected, only a small percentage of cocaine users have come into contact with treatment services.

The study reveals that the snorting of cocaine hydrochloride is by far the most popular use of coca products worldwide, while the smoking of coca paste and crack, and the injection of cocaine hydrochloride tend to be found among the minority of the socially marginalized and cause the greatest harm. The traditional use of coca leaf is still widespread among some indigenous populations in Argentina, Bolivia, northern Chile, Ecuador, and Peru, as well as some groups in Brazil and Colombia.

Researchers from the study recommend that education, treatment and rehabilitation programmes need to be strengthened and expanded to complement law enforcement measures. It is anticipated that the information gathered from this study will be used to develop more effective educational and preventive programmes. Another recommendation they make is to ensure that the cocaine problem is taken into account by all governments within the expanded national strategies for drug abuse control and in health plans.

The report of the study will be made available after careful peer review by a group of independent experts. ■

All aspects of cocaine use have been studied by many research workers.

Street children

Donald C. Kaminsky

Street children often sniff glue as a means of escape from their harsh lives, but this practice is harmful for their health.

Rapid urbanization and economic stagnation in much of the developing world have contributed to a growing social problem today: the street children. Not all street children abuse glue and other addictive substances, but all of them must be considered at high risk.

Between 5% and 15% of the children seen in the streets have completely abandoned their homes, and form part of a street subculture where violence, abuse, delinquency and substance use are a daily part of life. Once a child has entered this subculture it is difficult to extricate him or her from it. Children as young as eight or even six years can be found using psychoactive substances; adolescents can be found who have lived for eight or ten years on the streets and are dependent on some substance, whether licit or illicit.

Just one example: in Tegucigalpa, capital of Honduras, Oscar is 16 years old and has been living on the streets for six years. He shines shoes most of the day and hauls heavy packages the rest of the time. He hangs out with a small group of other adolescent boys. All of them sniff glue and all are chronically dependent.

Many unfeeling observers considered them to be "throw-away kids", but in reality they are children deprived of their most basic children's rights.

In all parts of the developing world, glue is the substance which is most abused. It is cheap, easily obtained and provides a "rapid high" for the street children. Most frequently it is the first substance used; with the passage of time the youngsters may add marijuana, alcohol, cigarettes and stimulants to the list. Sometimes they are used separately, at other times simultaneously.

Glue is only one item in a list of over 1400 commercial items which fall into the category of inhalants and can potentially be abused in consumer societies. But in the developing world, where the problem is most acute and extensive, glue is most often involved, followed by paint thinners and gasoline. A recent phenomenon in Central America is to mix the glue with the thinners or gasoline.

Clinical effects

Depending on the solvent found in a given substance, different clinical presentations will be seen after chronic use. In Central America, for instance, a very common solvent found in shoemaker's glue is toluene, which can cause dependence and affect the central nervous system but not the peripheral nervous system. Recently it has become common to mix toluene-containing glue products with paint thinners or gasoline which contain *N*-hexane and cause peripheral nervous system effects. So children are starting to be seen with dysfunction of both the central and peripheral nervous system.

When long-term use patterns are coupled with the use of high doses of inhalants, almost all major organ systems can potentially be involved, but the nervous system is the one we see most frequently clinically affected. Street children usually do not die from the direct effects of inhalants, but from accidents which occur when they are under the influence of the substances.

Depending on local price structures and availability, these young people may start to use other substances such as cocaine. Over a recent two-year period in Costa Rica, the prevalent use pattern changed from glue sniffing to cocaine use. It is essential to be constantly vigilant to the changing patterns of use in our communities.

A high proportion of the street children have been driven out from homes where violence and alcohol problems persist and are the norm. A pattern of substance use begins to take place, with the present genera-

tion living out their drug dependence in the streets. Many unfeeling observers considered them to be "throw-away kids", but in reality they are children deprived of their most basic children's rights, who remind us of the significant social, cultural and economic disruptions in families and communities in many developing countries today.

Special rehabilitation programmes are necessary for these children. Three phases are necessary. The first takes place on the streets and is usually carried out by a new type of professional who is called a street educator. This outreach worker makes contact with the street children, becomes their friend and advocate, provides them with counselling and helps them to re-establish trust in society and the adult world. This phase may take six to nine months or longer. Then it is necessary to refer the young persons to a diagnostic centre where their physical, psychological and social problems will be studied and a treatment plan established. This second phase may take a week. The children are then referred to a closed centre for psychosocial and medical treatment. This third phase can take nine months or longer, depending on the diagnosis. Comprehensive types of rehabilitation programme like this are hard to find, but it is necessary to establish such programmes if we are to assist the street children to leave the unfriendly streets and conquer their drug problems.

Another group of disadvantaged youth are those who are found working in the informal sector in the developing countries. Part of the time they may or may not be attending school. The number of girls in this group is much larger, and the group as a whole are rarely using substances. But they may experiment as adolescents and are therefore a high-risk group for potential substance abuse because of their poverty, their constant exposure to highly stressful situations, and their general lack of protective factors. Education and counselling programmes are very important for them – not least because all the indications are that the numbers of street children will increase in the future. ■

Shoeshine boys in Honduras. Children living on the streets need health programmes that they can understand and accept.

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Volatile solvents

Increasing use of volatile solvents ("glue-sniffing") and its related consequences, especially among young people, is causing worldwide concern. The substances used include products that are widely available at home and in industry, such as glue, petrol, paint thinners, domestic polish and aerosol sprays. These solvents are usually sniffed or inhaled directly from containers, plastic bags or saturated cloths, or they are sprayed directly into the mouth.

Their ready availability, accessibility and low cost and the rapidity of mood alteration following inhalation make these substances particularly attractive to young people, especially those from poorer backgrounds, including street children. The harm they cause ranges from neurological and psychological dysfunctions and liver and kidney damage to sudden death.

Such problems can best be prevented by broad-based strategies within communities, by building partnerships between users on the one hand and, on the other, parents, teachers, nongovernmental organizations, retailers, manufacturers, police and health and other professionals. Education aimed at changing behaviour and encouraging healthier choices is essential.

National Advisory Committees on Solvent Abuse could bring together representatives of such bodies as the police, justice, social welfare, education and health as well as interested nongovernmental agencies. An action plan should be developed, working directly with young people and communities to assess needs, identify gaps in services, determine funding requirements, and develop resources and public education programmes. Community-based programmes can offer a range of services, such as daily activities, drop-in centres, referral to drug counsellors, street educators and residential programmes. Countries which have adopted such approaches, including New Zealand and the Philippines, have detected measurable decreases in the prevalence of substance abuse.

WHO's Programme on Substance Abuse initiated a project in 1992 to determine the extent and nature of this problem, and a framework has been developed which is currently being tried out in seven countries.

Contributed by Dr Maristela G. Monteiro, Medical Officer, Programme on Substance Abuse, World Health Organization, 1211 Geneva 27, Switzerland.

Smoking in the Third World

Sherif Omar

Children who smoke daily are 13 times more likely to use heroin than children who smoke less often; an estimated 3000 children become dependent on tobacco every single day.

Unfortunately more and more children start using cigarettes

Ten years ago, WHO warned that smoking diseases will appear in developing countries before communicable diseases and malnutrition have been controlled, thus further widening the gap between rich and poor countries. The Director of the Pan American Health Organization (PAHO) said that tobacco is likely to become Latin America's 21st century plague and that, unless action is taken now, from the year 2000 tens of thousands of Latin Americans will die each year prematurely from tobacco-caused diseases.

In the least developed countries, where life expectancy is only 45 to 50 years, chronic diseases like lung cancer and heart disease are generally uncommon because relatively few people survive to those ages when such diseases become manifest. In most developing countries, health data and figures showing the patterns of tobacco use are poor and unreliable. Yet smoking is particularly risky in poor countries where populations are anaemic because it reduces their blood's oxygen-carrying ability. Very poor people often use tobacco as an appetite suppressant – a cheap and accessible means of warding off hunger pangs. Few governments in the Third World are keen on making decisions that might deny such people the small consolation obtained from smoking or chewing modest amounts of tobacco. Moreover, tobacco is not just a health issue, it has considerable economic force with social overtones.

The area of land under tobacco cultivation throughout the world was 4109 hectares in 1985, 73% of it in developing countries. Tobacco occupies three hectares in every thousand of the world's arable land, and the total profits on this crop per hectare are normally five times that of maize, and three to four times that of cotton or peanuts. Some important questions arise: How can alternative crops be encouraged? Why is the tobacco industry so favoured? What would happen if funds currently used for tobacco cultivation were transferred to other crops? The answers lie in the power of the transnational tobacco companies and their massive financial influence.

Anti-smoking messages

Campaigns against smoking require a huge financial commitment if they are to spread health education messages to hundreds of millions of people living in populous countries like Brazil, China and Indonesia. Immense barriers stand in the way of widespread dissemination of health education against tobacco in the least developed countries, with their high rate of illiteracy and relatively poor outreach of television and newspapers.

Doctors are often in powerful positions to influence both patients and government policy, and this potential has been acknowledged by WHO and nongovernmental organizations like the International Union against Cancer (UICC). But in developing countries, this is not the case and, indeed, medical professionals are among the groups who smoke most.

In developed countries, the tobacco burden is estimated at 16% of all cancer cases every year, while in developing countries it is 10%. In total, of the 676 000 cases of lung cancer in men, 85% are attributable to smoking. Where males have smoked for several decades, 30–40% of all men's cancers are attributable to tobacco. Unless control efforts are strengthened in the developing countries, the enormous rise in cigarette consumption will produce a comparable rise in cancer in those countries within the next 20 to 30 years.

In the Middle East, some 50% of the population are below the age of 20, and they are the target of tobacco propaganda seeking to motivate them to start and continue as regular smokers. Smoking behaviour started centuries ago but as a social habit it is still gaining ground; around 40% of the males above the age of 12 are regular daily smokers, although smoking among women is still low. In certain countries about 25% of the daily smokers use the hookah or hubble-bubble.

Although there have been some moves to condemn smoking on Islamic religious grounds, legislation against smoking is not seriously implemented in most countries even though the tobacco business often violates the law, especially as regards sales promotion and advertisement. An early WHO report drew attention to the threat to the Third World from multinational tobacco companies seeking new markets. A later report concluded that the threat had become a reality.

Sachets of "pan masala", a mixture of waste tobacco leaves and floor sweepings from cigarette factories, are sold cheaply in India and prove particularly attractive to children.

The new concept that smoking induces nicotine dependence means that this is considered an addictive drug. This fact is gaining support from international scientific agencies. Many studies, including some which have been concealed by the tobacco industry, show that nicotine does produce chemical reactions in the body similar to those produced by heroin or cocaine. The relapse rates of dependent persons trying to quit using nicotine, alcohol, cocaine and heroin are roughly the same; many even report that it is harder to quit tobacco than various illegal drugs.

A new study by the Center on Addiction and Substance Abuse at Columbia University in the USA confirms that nicotine is a "gateway drug" which is associated with the use of illicit substances. About 65% of cocaine users in the USA have smoked cigarettes. Adults who started to smoke before the age of 15 are three times as likely to be regular hard drug users and more than twice as likely to be regular cocaine users than those who started smoking at 18 or older. Children who smoke daily are 13 times more likely to use heroin than children who smoke less often.

Anti-smoking policies must be identified as part of every health strategy in the least developed countries. Health education, public information and smoking cessation programmes must work hand in hand with the legal regulation of tobacco production and sales and the banning of advertisements. ■

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The tobacco habit has reached every part of the world.

Young tobacco users

S.G. Vaidya

Children who are well informed about the harm done by cigarettes can be powerful agents for reducing tobacco use

Children in India have been found to be the most powerful agents of change in reducing the prevalence and uptake of tobacco smoking, in both adults and children.

K was aged 12 and had tried a cigarette once or twice, three of his uncles being smokers. He did not like it much. But soon his parents became worried because his school performance dropped. Three months later they discovered that he had become a victim of *pan masala*, a product made out of waste tobacco, mid-ribs of tobacco leaf and floor sweepings from cigarette factories. The packets are sold at affordable prices with attractive, shiny coloured wrappings. Since K was consuming three or four packets a day, his pocket money was not enough and he started stealing and lying, so much so that the parents sought medical help. They also warned the trader not to sell the tobacco to children.

Some 20% of the Indian population is aged between 10 and 15 years, and the tobacco industry exploits this fact. The children are not only the victims, but their poverty leads them to become vendors and to roll cigarettes as well. To taste and use what they sell is an easy road to dependence.

It is estimated that in India almost every second adult has a tobacco dependence, every 5th child starts experimenting with tobacco and every 10th child is hooked on tobacco. The pervasive effect of almost 60% of households using tobacco in the form of chewing paste, pan masala and beedis (primitive cigarettes) in rural homes and manufactured cigarettes in urban homes, and of advertisements vaunting smoking as the road to Western sophistication, gives the cigarette industry every reason to believe it can increase cigarette production by some 60% by the year 2000.

Already 20 million children are dependent on tobacco, according to a survey by the government's National Sample Survey Organization. To this astounding figure, about 5500 new users are added every day – a total of two million new users a year. The marketing strategy of the tobacco industry receives powerful backing.

The art of dissuasion

Fourteen-year-old P ran away from home, leaving behind a note to his father, a heavy smoker. "If you don't quit smoking, I will not return", he wrote. He stayed with his uncle until his father arrived with a firm commitment to quit – and he kept his promise. All his previous attempts to quit had failed.

A whole class of about 40 children greeted their headmaster by raising silent but explicit placards reading: "Sir, we love you; Sir, we want you; Sir, smoking causes cancer". The headmaster, a chain-smoker, had no option but to quit. Responsible for 1500 schoolchildren, he felt he had to take part in the anti-tobacco education programme, and that meant setting an example.

A research project funded by the Indian Council of Medical Research tested the efficacy of anti-tobacco community education. The three participating agencies were 20 000 rural schoolchildren from 74 schools, paramedical workers in primary health centres, and village social workers. All three groups were given anti-tobacco education and motivational training. A positive change in attitude and behaviour towards tobacco use was found not only in children but also among teachers, as compared with the control group. In addition, children were found to be the most powerful agents of change in reducing the prevalence and uptake of tobacco smoking, in both adults and children.

To control the tobacco epidemic in children, a two-pronged attack is necessary. Firstly, strong legislation is needed to ban all pro-tobacco propaganda aimed at converting young impressionable minds into addicts. Secondly, anti-tobacco education in schools should be made mandatory, and it should be complemented by nationwide anti-tobacco media campaigns wholeheartedly backed by the government. ■

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A tobacco-advertising-free world by the year 2000?

Judith Mackay

In 1986 the World Health Assembly recommended the adoption of comprehensive tobacco control measures to eliminate the promotion of tobacco. The Health Assembly reiterated this call in 1990, and urged Member States to consider eliminating all direct and indirect tobacco advertising, promotion and sponsorship.

Such recommendations aim to protect young people from pressures to smoke, to assist smokers in quitting, to challenge and reduce the social acceptability of smoking, and to free the media, sports, arts, youth pop culture and other organizations from the influences of tobacco revenue. But tobacco advertising remains widespread throughout the world – on TV, radio, newspapers, magazines and bill boards – and newer and more sophisticated forms of promotion are being introduced.

About 20 countries worldwide have already enacted total advertising bans, while many more have partial bans. The global trend is clearly towards more and more restrictions on tobacco promotion. What is clear from these precedents is that voluntary agreements with the tobacco industry are far less effective than legislation; partial bans have only partial success, and a total ban on all advertising and promotion is a crucial component of a comprehensive tobacco control strategy.

Perhaps the best evaluation of advertising bans comes indirectly from the tobacco industry itself. In practice, the industry strenuously opposes bans on tobacco promotion – surely a good indication that this is an effective measure for governments to undertake. Total bans are vital as tobacco-related mortality is rising rapidly, especially in developing countries, which are the least able to bear the health and economic costs of this epidemic. If current smoking trends persist, the global annual tobacco death toll of 3 million will rise to 10 million by the 2020s or 2030s, with 7 million of these deaths in the developing countries.

Advertising bans are not an infringement of civil liberties (as the tobacco industry argues), but an example of prudent public health policy. Advertising of many lawful substances and services (e.g., medical and legal services, prescription drugs) is, for different reasons, already banned in different countries. Individuals accept all sorts of limitations on freedom in the interests of the public good – for example, everyone respecting the rule of the road.

Most people believe it is not an infringement of freedom but a *responsibility* of governments to take action and legislate against dangerous workplace practices that put workers' health or lives at risk. No one should be free in any society to harm others, and this principle applies to the tobacco industry, which should not promote their dangerous product.

History will look back and ask why it took us so long to ban tobacco advertising. Future generations will have difficulty in comprehending why glamorous and seductive promotions were allowed of a product which, for over 30 years, was known to be dangerous and addictive – killing one in two of its lifelong users.

The time has come – in fact, is long overdue – to put an end to the tobacco industry's aggressive campaigns. Let us aim for a "Tobacco-advertising-free World by the Year 2000". Our children deserve no less. ■

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In the next issue

A vast number of people throughout the world are suffering from physical or mental disabilities. Giving them all the chances of living a fulfilling life is one of the greatest concerns of the health community today. The September-October issue of ***World Health*** will describe the many facets of this challenge. ■

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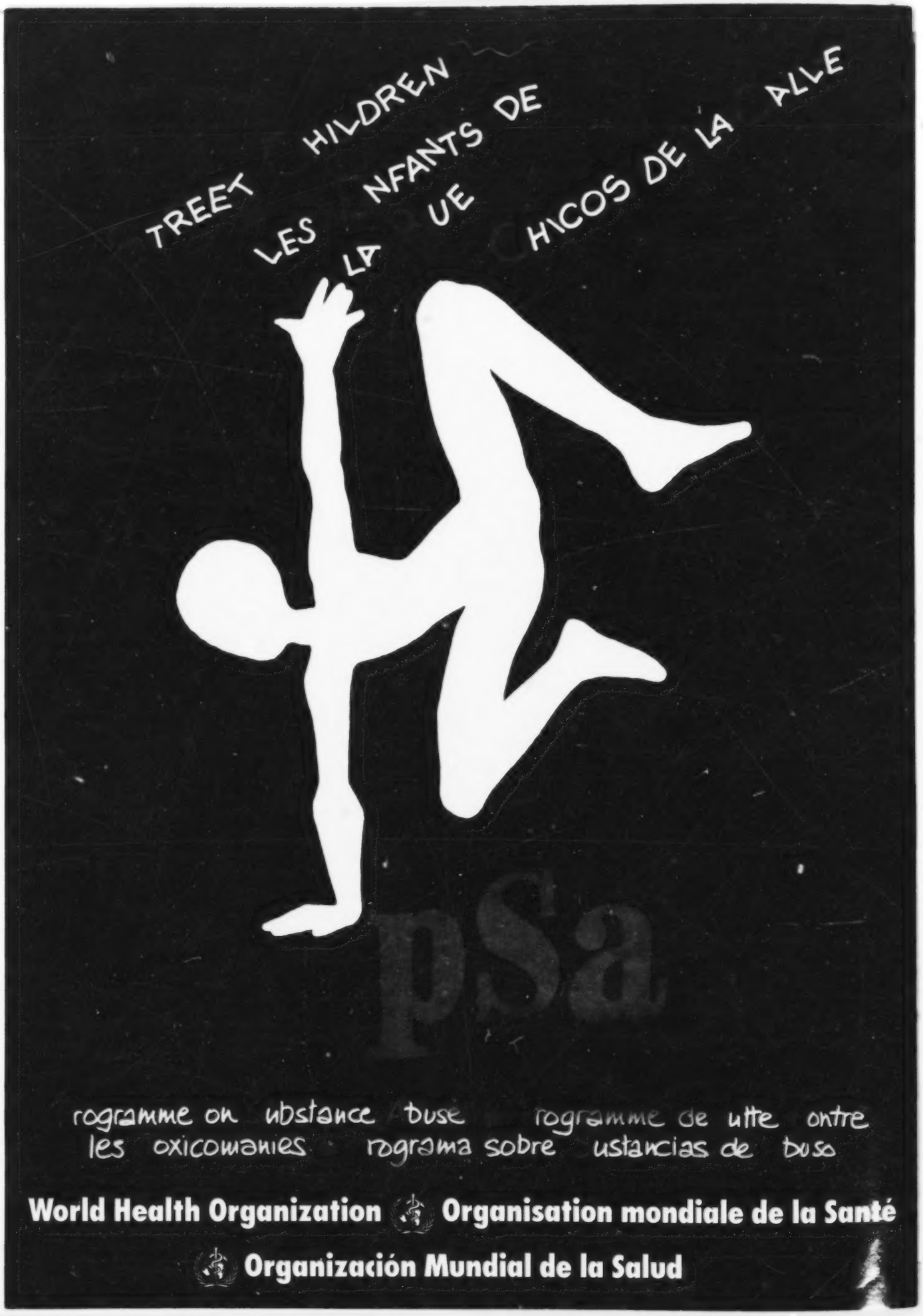
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